

"Coding Logic Error" and fun with ICD-10 codes

From p-flagrant lies to p-coding logic error to p-ICD-10 code-buggery



Jessica Rose5 hr ago

♡117

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Update: Thank you to ‘That Day’ for the comment! Watch [this](#) short clip from Ivor Cummins.

I feel like it might be time to clear up this whole thing about ‘COVID deaths’.

Now we all know about the ‘Coding Logic Error’ kerfuffle that happened in March. If you do not, you can read [this](#). To summarize, the death counts reported (and repeated incessantly) in kids in America due to COVID-19 were not correct. Once the ‘Coding Logic Error’ was corrected, at least 1/4 of all of the reported deaths were found to be erroneous. In other words, those kids didn’t die from COVID-19. If this doesn’t shake you up, check yourself.

Please go to this Substack article.



John Dee's Almanac

Excess Mortality Due to COVID

Yesterday I revealed the monthly series for non-COVID mortality for England & Wales for the period 1970 – 2021 and compared this with all cause mortality. This morning it made sense to subtract one set of figures from the other and arrive at an estimated of excess mortality due to COVID. In the plot below you’ll see two nicely defined waves, the second ...

Read more

5 hours ago · 7 likes · John Dee

Now read the paragraphs in the following screenshot until you really and truly understand their meaning. And then call your MP, your Senator, your judge, everyone and start screaming fraud.

"With reference to *section 4.2.3 of volume 2 of ICD-10, the purpose of mortality classification (coding) is to produce the most useful cause of death statistics possible. Thus, whether a sequence is listed as 'rejected' or 'accepted' may reflect interests of importance for public health rather than what is acceptable from a purely medical point of view. Therefore, always apply these instructions, whether they can be considered medically correct or not.*"

Neither is that the end of it because a fancy bit of software called MUSE 5.8 (Multicausal & Unicausal Selection Engine) decides what eventually gets coded as an underlying cause of death. Until we independently audit this system against the original death certificates we'll never know whether what a physician decided is what turns up in the statistics. The slippery nature of all this is why eminent bods prefer to analyse all cause mortality in order to ascertain what might have been going on as opposed to what the authorities claim has been going on.

You can go [here](#) to confirm this atrociousness. One thing that struck me in particular (because of my love of the [RAAS](#)), was the part on the ‘changes and comparability ratios following dual coding by MUSE 5.5 and MUSE 5.8 for selected leading causes of death’. Take a look at Table 3 in the document and refer to E86 to E87. -44% change?

That’s huge. This applies to leading cause of death being: ‘Disorders of fluid, electrolyte’. Funny that the Renin Angiotensin Aldosterone System regulates electrolyte levels and depends on ACE-2 to do so. Just saying.

They write:

The data analysed [in this paper](#) is based on the original software coding without revision. This means that, unlike our finalised death registrations, this data has not been subject to full quality checks and any further information on the death that is provided that *may revise the cause of death* has not been included.

So what this means is that many of the so-called COVID-19 deaths, were in fact, not.

The following Table (Table 1) shows the differences between the counts of deaths (underlying cause of death (UCOD)) according to the versions of the software (there’s IRIS 4.2.3, MUSE 5.5 and MUSE 5.8). The updated version (MUSE 5.8) resulted in dramatic differences in causes of death. Well, I would call 599 dramatic. This is the difference in leading cause between MUSE 5.5 and 5.8. Imagine all 599 of these were COVID-19 deaths removed as the leading cause of death. In other words, person died ‘with COVID’ and not ‘from COVID’.

Table 1: Record level changes in under-lying cause of death (UCOD) designation between coding by IRIS 4.2.3, MUSE 5.5 and MUSE 5.8 and consequential impact by ICD-10 level and leading cause						
Coding versions		UCOD	Block	Sub-chapter	Chapter	Leading cause
IRIS 4.2.3 and MUSE 5.5	Agreement	39,298	40,821	41,310	41,533	41,193
	Disagreement	3,115	1,592	1,103	880	1,220
MUSE 5.5 and MUSE 5.8	Agreement	41,125	41,435	41,905	42,069	41,814
	Disagreement	1,288	978	508	344	599
IRIS 4.2.3 and MUSE 5.8	Agreement	38,981	40,602	41,220	41,459	41,078
	Disagreement	3,432	1,811	1,193	954	1,335
IRIS 4.2.3, MUSE 5.5 and MUSE 5.8	Agreement (3 way)	38,624	40,266	41,027	41,331	40,852
	Disagreement (3 way)	257	87	32	14	32

Source: Office for National Statistics

I have not for one iota of a second considered analyzing data involving ‘deaths’ and ‘cases’ because the data is sheit. Here’s proof. There’s no polite way to say it. The COVID-19 pandemic/panorama/circus is a farse - a bad board game that everyone is sick of playing. The shots that came as a ‘solution’? My God. The humanity.

The overall proportion of records with an underlying cause of death coded to a different leading cause by MUSE 5.5 and MUSE 5.8 was 1.4%.

Now you might be thinking, 1.4% doesn’t sound that bad right? Well, maybe not as a standalone alteration. But one of the things that keeps repeating in the context of data when it has anything to do with COVID is INCONSISTENCY. This is an example with a clear explanation of how inconsistencies in death counts can come about, but this is just one example of what we know about. And not many people know about it! What *don’t* we know about with regard to [inconsistencies](#) in COVID data? And in this particular case, how would the correct classifications of causes of death change the public health narrative? Would a single kid have died from COVID-19 at all? [Marty Makary](#) would [probably say no](#). Would we have this so-called emergency? Of course not. You’ve been gamed.

Opinion > Marty Makary, MD, MPH

Think Twice Before Giving the COVID Vax to Healthy Kids

— Based on the data to date, there's no compelling case for it right now

by Martin Makary MD, MPH, Editor-in-Chief, MedPage Today June 10, 2021



Don’t even get me started on bloody ‘cases’.

Please also refer to [this Substack article](#) written by John Dee.


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117 likes


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Just Me · 4 hr ago · [Liked by Jessica Rose](#)

Now wouldn't you think the outrage from this would make MSM during prime time?! Your digging and your findings are extremely eye-opening! Shattering! I need to read through it again, and probably again!

Do you know how when you go in the grocery store they have those bulletin boards people can pin things on? I say we start copying out all this information and leave it in strategic places for people to see. Who knows? Everyone persons all life that can be made aware will just keep spreading.

♡ 24 · Reply · Collapse

7 replies by Jessica Rose and others



That Day · Writes That's Newsletter · 3 hr ago · [Liked by Jessica Rose](#)

Jessica... Ivor Cummins presents some useful death data by age in Ireland.. death rate by age declined over 20,21

See his YouTube Channel..no excess deaths... <https://youtube.com/watch?v=uKpnLda6hS4&feature=share>

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Jessica Rose PhD, MSc, BSc and Peter A. McCullough MD, MPH

Jessica Rose · Nov 2, 2021 · ♡ 1,178 · 💬 139 · 🔗

I don't know what to say...

The results are in for the 'Efficacy' (uh, safety is a better word) of the mod-e-RNA shots.

Jessica Rose · Feb 2 · ♡ 402 · 💬 301 · 🔗

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